CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Andy Beshear
Governor

Pam Smith
Division Director

275 East Main Street, 6W-B
Frankfort, KY 40621
www.chfs.ky.gov

Eric C. Friedlander
Acting Secretary

Stephanie M. Bates
Acting Commissioner

To: All 1915(c) Home and Community Based Services Waiver Providers

From: Pam Smith
Director, Division of Community Alternatives

Date: January 8, 2020

Re: Update on Reconsiderations

The Department for Medicaid Services (DMS) is notifying providers of a change in the reconsideration process. Providers can request a reconsideration when they disagree with an adverse action by DMS. In the past, DMS staff who were not involved in the adverse action reviewed reconsideration requests. Beginning this month, the Cabinet for Health and Family Services' Office of the Ombudsman will review reconsideration requests for DMS.

This policy shift will benefit all 1915(c) Home and Community Based Services (HCBS) waiver stakeholders. The Office of the Ombudsman works to ensure individuals receiving public services are treated appropriately and staff members are not involved in DMS decisions that result in adverse actions.

DMS has released an updated information sheet regarding reconsiderations, appeals, and grievances. It is available online at https://chfs.ky.gov/agencies/dms/dca/Documents/whatdoesthismeantomeAG.pdf. This information is also being shared with participants in all 1915(c) HCBS waivers.

If you have questions, please contact the 1915(c) Waiver Help Desk by calling (844) 784-5614 or emailing 1915cwaiverhelpdesk@ky.gov.

Sincerely,

Pam Smith

Pam Smith
Director, Division of Community Alternatives

What Does This Mean to Me? Reconsiderations, Appeals and Grievances

January 2020

The Commonwealth of Kentucky allows participants to voice disagreements and complaints with the Department for Medicaid Services (DMS) about their 1915(c) Home and Community Based Services (HCBS) waiver services. DMS has methods in place to support how you voice your disagreement or complaint, as well as how we must respond. When you share your disagreement or complaint, keep in mind:

- DMS must consider all sides and available facts.
- DMS cannot dis-enroll you from the waiver for requesting an appeal or submitting a grievance.
- DMS cannot treat you differently because you let us know you did not like something.

There are three ways to voice your waiver disagreements or concerns: reconsiderations, appeals or grievances.

Reconsideration

- You can ask for a ***reconsideration*** when you receive an ***adverse action*** from DMS. An ***adverse action*** is a decision about your care such as a denial of level of care or the services you can receive. You will receive an ***adverse action notice*** when this type of decision is made.
- To request a ***reconsideration***, you must make your request in writing within 14 days of the date on your ***adverse action*** notice. You should mail your request to:

  Office of the Ombudsman and Administrative Review
  Medicaid Appeals and Reconsiderations
  275 East Main Street 2E-O
  Frankfort, Kentucky 40621

- The Office of the Ombudsman staff will complete the ***reconsideration*** review. These staff members work on behalf of individuals to ensure they are treated appropriately. They are not part of DMS and, therefore, are not involved in the original determinations they are asked to reconsider.

Appeal

- You can file an ***appeal***, in addition to a ***reconsideration***, when you disagree with an ***adverse action*** by DMS.
- To file an appeal, you must write a letter requesting an ***administrative hearing*** and send it to DMS within 30 calendar days of the date on your ***adverse action*** notice.
- Only a participant, or his or her authorized representative, such as a guardian or legally designated power of attorney may make this request. Appeals should be sent to:

  Office of the Ombudsman and Administrative Review
  Medicaid Appeals and Reconsiderations
  275 East Main Street 2E-O
  Frankfort, Kentucky 40621

- An ***administrative hearing*** will be held to determine if the ***adverse action*** should stay the same or be changed.

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- If you wish to continue receiving services, your request for an ***administrative hearing*** must be postmarked or received within ten calendar days of the date on the ***adverse action notice***.
- You have the right to review the case record relating to the issue and submit additional information in support of your claim.
- At the hearing, waiver participants, applicants, authorized representatives or guardians may be represented by legal counsel, a relative, a friend, or other spokesperson or you may represent yourself.

Grievance

- You can file a ***grievance*** when you are unhappy with DMS, a provider or your waiver services. ***You do not need to have received an adverse action in order to file a grievance.***
- ***Grievances*** may include but are not limited to, the quality of care or services you receive, a problem with a provider or an employee, or a violation of your rights as a waiver participant, or a dispute about the time it takes DMS to make service decisions.
- To file a ***grievance***, you can fill out the attached form and email it to 1915cwaiverhelpdesk@ky.gov or mail it to:

  Department for Medicaid Services
  Division of Community Alternatives
  275 East Main Street, 6W-B
  Frankfort, Kentucky 40621

If you need assistance filing a grievance or appeal, you may contact the Office of the Ombudsman and Administrative Review at (800) 372-2973 **OR** the Department of Community Based Services located in your county regarding the availability of free representation by legal aid services.

Kentucky Department for Medicaid Services
1915(c) Waiver Grievance Form

Once completed, please email form to 1915cwaiverhelpdesk@ky.gov or mail it to:
Department for Medicaid Services
Division of Community Alternatives
275 E. Main St., 6W-B
Frankfort, Kentucky 40621

Date

Name of Person Filing Grievance

Email Address

Phone Number

Check One:

□ I am a waiver participant.

□ I am filing a grievance on behalf of a waiver participant.*

***If filing on behalf of a waiver participant, please state your relationship to the individual:**

_____

Waiver Participant Information

Participant's Name

Participant's Address

Participant's Date of Birth

Participant's MAID Number

Please Explain Your Grievance
Click or tap here to enter text.

Please Explain Your Desired Outcome
Click or tap here to enter text.

Signature of Person Filing Grievance | **Date**

Information below to be completed by DMS staff.

Received By (Please Print Name) | **Date**